Clinical Advisory Pharmacists Association

Newsletter – May 2017

An update after a busy time. While things seem quiet there has been action behind the scenes.

Workshops

1. Clinical pharmacists in general practice day

December 2nd 2016

This day, held at the Wellington Club involved 24 pharmacists gathering to talk about their roles and their needs. It was an excellent chance for networking. Notes from the meeting are attached (Appendix 1)

2. Pain Management day

Feb 17th 2017

With changes to the provision of pain management by ACC, and the new model of service delivery involving inter-professional teams, CAPA organized a day to look at the management of chronic back pain, and particularly the role of non-pharmacological treatments. We were fortunate to have Associate Prof Peter Jones (rheumatologist), Chris Gregg (physiotherapist), John Moffatt (clinical psychologist) and Carolyn Woolerton and Pauline McQuoid (clinical advisory pharmacists) present to 22 participants. This generated a lot of interesting discussion and imporved our understanding of the new models of care for back pain.

3. Forward Pharmacy

April 12th 2017

This was a meeting organised by the two Schools of Pharmacy to look at the way forward for research and supporting pharmacists in future services. Billy Allen presented a snapshot of clinical advisory pharmacists working in general practice, and Linda Bryant presented information on pharmacist prescribers in general practice.

4. Meetings

We have had representation at the following meeting – HOSPOP, PRISM, and Pharmacy Workforce development. There is also a regular meeting with the Andi Shirtcliffe our Chief Pharmacy Advisor, and other meetings with people at the Ministry of Health on pharmacy licensing, and the NZMA

5. Submissions

Submissions have been made to Ministry of Business, Innovation and Employment supporting the proposal for pharmacists to be recognized as ACC treatment providers, and to the Health Workforce New Zealand supporting the post-entry education funding ($185 million) becoming contestable.

6. Future plans

Moving forward we are planning an audioconference / Webinar on Refugee Health for later this year, and for next year a somewhat larger education session on precision medicine, focusing on the new 'biologicals', starting from the foundations of molecular medicine, immunology and infections and working through to the current innovative medicines that we are using more and more.

7. Last but not least – member's activities

Kerry Muller has attended the World Integration Care Congress and presented her work on pharmacist prescribers and ….

★Congratulations to John Dunlop for being awarded the PSNZ Gold Medal

An inspirational leader and an amazing contribution to the direction of pharmacy

Appendix 1.

Clinical Pharmacists working within general practices
Peer Support and Role Development Day

Dec 2nd 2016, Wellington

Notes

Welcome and thank you to all the pharmacists who travelled to Wellington for the day to participate in this one day workshop. A wonderful collection of dynamic and innovative pharmacists.

Attendees, and roles, as introduced around the table

Name	Role	Issues / challenges
Shirin NAMJOU Christchurch	Works in two general practices	Getting general practitioners to understand what we are doing The perceptions of other pharmacists (lack of understanding of the roles, depth required)
Marilyn TUCKER Wellington	Kaori Medical Centre (medication reviews, clinical audits), and Compass as a facilitator (Integrated care project). Been working over 20 years in this environment	How to communicate the findings of a medication review – tried tasking, daily record, letters. Difficult as these disappear from the sight of the general practitioner after one or two consultations Complexities of the patients
Helen CANT Tokaroa	In general practice – with the medical centre and hospital I the same building; well integrated Also has a pharmacist prescriber and mobile MUR pharmacists (education, home visits) Sees complex patients, does medicines information Been in this role 3 years.	The lack of time to see the general practitioners to discuss complex patients
Michael HAMMOND Rotorua	Does medication reviews in 10 of the 17 general practices Works with two nurses and two pharmacists with complex chronic care patients in the home; and involved in the ACC pain management service and hospital discharge service	The slow speed of uptake of recommendations
Martin MUNYARADZI Hawke Bay	Works in one general practice undertaking clinical medication reviews and drug utilization reviews	How to prove that we are effective
Anne DENTON Hawke Bay	Team leader for the Hawke Bay pharmacist facilitators (8 FTE and requires 4 more) Undertakes audits across practices e.g. etidronate, amiodarone	Getting pharmacists into the roles
Bernie McKONE Gore	Has two community pharmacies that he is exiting from. Has been on the Well South PHO board for 6 years and chaired the clinical committee for 3 years. There are 290,000 patients, 40% being rural. Instrumental in getting $1.7 million to establish 5.2 FTE clinical pharmacists in general practice. Does medication reviews for the ACC pain management contract	Integrating pharmacists into the primary care workforce Getting work done in three days a week Building trust between clinical and community colleagues Wages are important – must not lose ground

Eui-Jin KIM Rotorua	Works with high-risk patients in 16 general practices; screens all high-risk patients and works with the chronic care support team. Sees hospital discharge patients. Started role in Feb 2016	Is spread very thinly Managing expectations And lack of time to do follow ups
Pam DUNCAN Wellington	Professional Standards Advisor for Pharmacy Council of NZ, plus project work around legislation, scopes of practice, competencies Community pharmacist in the Hutt Valley. Has a clinical governance role analyzing acute demand	Not enough hours in the day Knowing how we measure what we are doing
Brendan DUCK Hawke Bay	Is a DHB pharmacist facilitator three days a week; and two days a week in general practice as a prescriber, focusing on high risk patients, motivating change and changing medicines The traditional medication review model was not suitable in a large practice – need to prescribe to successfully implement the recommendations and manage patient outcomes	Initially nurses were a barrier, but now are great Time – general practitioner time and pharmacist prescriber time Some general practitioners want to see their patients every three months (young and old generally). The middle aged general practitioners are comfortable handing over the complex patients and those needing a quick change
Murray FOREMAN Tauranga / Tokaroa	Works M, W, F in Tokaroa as pharmacist prescriber. Initially hesitancy form general practitioners and nurses. Started with clinical audits and then implementing (e.g. gout); and does repeat prescribing Works with high-needs and rheumatic fever, and with the triage nurse Two days a week in Tauranga – primary / secondary care interface, discharge patients, patient education sessions	Time Others are initially hesitant – we are seen as a threat
Carolyn WOOLERTON Tauranga	Works for Medwise (with Pauline and Murray) undertaking domiciliary visits with referrals from several sources. Works one day a week in a general practice – a pharmacist prescriber	Selling ourselves and others seeing that we can do jobs that were previously seen as 'nurses' roles
Karen LOMBARD Palmerston North	Part of a 1.4 FTE team in Mid-Central (Palmerston North). Optimising medicines, involving population level clinical audits rather than individual reviews. Uses a trigger tool to identify people at risk. Primarily works in two large practices every week, and then smaller practices as needed	Quantifying what we do and showing our value. Getting general practitioner time, and accessing resources
Fiona CORBIN Whanaganui	Contracted to the PHO and Integrated Family Health Centre as a prescribing pharmacist and hospital locum (Emergency Department) Professional advisory with the DHB	Limiting the damage caused by poor communication
Angela HARWOOD Dunedin	Has a three year contract with Well south PHO as a pharmacist facilitator. Expanding service and everyone appears happy with the first phase so looking to grow over the next five years	Sticking to the tasks and KPIs as the clinical pharmacists are starting to be used differently. Getting input and developing resources. Need to be able to focus on these. (time)
Beshata ALI Auckland	Was an intern in 2014 and has completed her PG Certificate. Works in a medical centre in Qwest Auckland doing MUR, CPMS, looks a discharge summaries.	Transitional clinical services Can only focus on 1 or 2 problems and people are more complex than that

	Is currently coordinating rather than undertaking clinical work	
Tess JAMES New Plymouth	Covering 30 practices in Taranaki for long term conditions. Seeing patient in the general practice and home visits (for DNAs and difficult to engage) for medication reviews – mainly education. Now focuses on four main practices so more regular Is part of the LTC and MDT team	Follow up s and being spread too thinly This also makes developing relationships difficult Geographical spread means it is a little once over lightly
Anna STEVENSON Auckland	PHO pharmacist facilitator – works in three general practices for a half day every week doing medication reviews, discharge summaries, follow ups. Rest of the time does population clinical audits (all practices), resthome reviews, auditing high risk medicines / antibiotics, and presents to patient groups	Doctors not realizing the benefits of a pharmacist beyond just the medicines Communication in the practices if short of time … hard to see the general practitioners and if you are not there you are forgotten. Needs more practice-based time
Kerry MULLER Wellington	Just comopeted her MSci(UK) and works in the Hutt Valley at three practices (5 clinics), focusing on diabetes, hypertension and high risk people. Transitioning between PHO facilitator and prescribing, but job description has not changed and PHO / DHB not intending to employ a pharmacist prescriber	DHB / PHO don't have any funding set aside for the pharmacist prescriber roles, or clinical advisory pharmacists seeing individual patients (population based audits) Funding (for the practice) is per patient so no time for 'paperwork', emdicines information etc
Penny CLARK	Works at three practices (Northcare) and has been there 6 years - is a prescribing pharmacist. Patients pay to see Penny – so if is difficult doing medicines information, education sessions etc in 'clinic time' as these are non-funded roles	Time …. Other things are being asked for such as support for the clinical team, mentoring, the DHB SLAT, developing the patient management system New roles – funding, recruitment, appropriately qualified
Pauline McQUOID Tauranga	Independent contractor with MedWise, providing clinical pharmacist services, MTA, CMM and group education. Works at the primary / secondary care interface A referral-based service	Identifying patinets can be difficult as few people know who they are and what they can provide
John DUNLOP Wellington	Previously worked at a high needs practice as a pharmacist prescriber. Now on the PSNZ Council and CAPA Board Was involved in developing the PSNZ / NZMA framework for the integration of pharmacists and medical practitioners	Getting acceptance of appropriate standards for pharmacists working in general practice, and getting suitable remuneration
Linda BRYANT Wellington	Working as a pharmacist prescriber 3 days a week in two high needs general practices	Getting recognition of the level of understanding of pharmacotherapy required to provide quality clinical services, and getting funding!

Apologies
Jenni Jones
Lynn Sloane

Clinical reasoning and decision making

Dr Chris Cameron, General Physician and Clinical Pharmacologist

General points

- Every patient is different
- Guidelines are single disease orientated – so very few people fit the guidelines
- With aging, organs change
- Perfection is not always feasible
- Clinical indicators will not always be ideal
- **What does the patient want?**

Statins and macrolides …

- Is the macrolide required?
- There is a difference between the statins and propensity to interactions – simvastatin very prone to interactions
- There is a difference between the macrolides - erythromycin and clarithromycin are more problematic

Statins and diltiazem …

- May get rhabdomyolysis even after the long-term combination if triggered by e.g. a bowls tournament, long walk etc

Phenytoin dosed at 870 mg daily, normal albumin and serum concentration within range

- And a seizure while on holiday
- Check if had a lot of alcohol while on holiday
- Check free phenytoin concentration

Tamsulosin, paracetamol, ibuprofen …. Headache in the morning 30 minutes after tablets

- Too soon for tablets to be absorbed
- ? medication overuse headache

How to down titrate long term bupropion used for smoking cessation

~ Monthly

Clinical advisory pharmacists' and prescribing pharmacists' activities

There is a lack, and in some cases a mis-understanding of what the work of a clinical advisory pharmacist involves, and the attributes and characteristics that are involved in this role.

When developing roles and standards, it is important that we are clear about these requirements.

In a pilot, the Activity Logs of 5 clinical advisory pharmacists (4 prescribers) for four days were collated. The following activities and characteristics were identified

General clinical advisory pharmacist roles

Patient clinics

- Review medicines for complex patients such as those with multiple comorbidities, potential adverse drug reactions, deteriorating renal function, uncontrolled long term conditions.

Resource

<u>For general practitioners</u>

- Complex medicines information enquiries, particularly those requiring quantification of benefits and risks for an individual
- Medicines reconciliation post-discharge, resolving any discrepancies, discussing changes with patients to clarify misunderstandings, and follow up for monitoring, adverse effects and dose titration
- Communicating, and coordinating when necessary, medicines between specialists
- Helping develop treatment plans
- Providing up dates on the latest changes in medicines therapy – independent critical appraisal of the literature. This is especially useful in rapidly changing areas such as COPD

<u>For nurses</u>

- Joint responsibility for Diabetes Annual Review
- Available for medicines information and presentations on medicines therapy

<u>For the practice</u>

- Assist with cardiovascular risk assessment and education, and smoking cessation
- Provide public health advice
- Communicate and coordinate with local community pharmacists and other heath care providers

Additional roles for prescribing pharmacists

- In addition to the above roles the prescribing pharmacists ran clinics for people with long term conditions and introduced medicines for blood pressure and glycaemic control, including insulin initiation, undertook dosage titrations, switching therapy
- Assessed patients and identified acute problems requiring referral for medical input
- Follow up of post-discharge patients, reconciliation, dosage adjustments and monitoring for effectiveness and adverse effects
- Managed Repeat prescriptions – clinical review and check with follow up as required

These pharmacists displayed characteristics that demonstrate a change in mind-set, perhaps due to their postgraduate qualifications and experience in primary or secondary care clinical services rather than community pharmacy. These included:

- Making definite decisions and recommendations, rather than just giving options
- Being able to identify and resolve problems from a holistic perspective and beyond just pharmaceutical matters
- Having ability to undertake a broad assessment
- Understanding the roles of other health care providers and when to refer
- Being person/whanau focused, but with benefit-risk evidence that is quantified to assist shared decision making.
- Able to recognise that ideal pharmacotherapy is not necessarily optimal for an individual

- Being evidence based and able to discuss the pros and cons of therapy for an individual from a base of understanding the underlying principles of pharmacotherapy

Being definite and responsible and accountable for the recommendations

PSNZ Salary bands for pharmacists

John Dunlop presented the proposed salary bands for pharmacists. An advantage of this was that it has encouraged the definition of roles, competencies and qualifications. It does require ratification by PSNZ.

There is a blurring of boundaries, but six possible bands were discussed. The concept needs ratification by the Pharmaceutical Society of NZ and also the Pharmacy Council. As it primarily applies to those pharmacists working in the community and in Primary Care, there will be a short delay while other interested parties are given an opportunity to comment.

Breakout groups - notes

Stream 1. Pharmacists in general practice – facilitated session

This session used the cases from presentations of pharmacists present to discuss prioritization of concerns a Clinical Advisory Pharmacist might be presented with.

The discussion attempted to illustrate that the first priority was not to focus on potential drug interactions and other medicines related problems, but to ensure that social and personal concerns were first understood.

The session tried to illustrate that it was necessary to understand the patient's living environment and their capacity and willingness to accept any changes that might be considered appropriate.

For example, suggesting a breakfast, and lunchtime adherence routine is not possible for someone working late shifts, and not rising till mid-morning.

Many other issues that might affect the patient's ability to benefit from the existing and or modified medication profile and regimen were covered in this session.

Stream 2. Prescribing pharmacists' session

How to measure what we do is still problematic

- *Once refined Kerry is willing to share her screening tool*
- Consider doing a two day Activity Log every six months (general practitioners and nurses don't have to justify their every outcome / role)

Leadership model for clinical services governance

We need to have CAPA / CAP's embedded in the clinical service development, implementation and governance in al the regions.

For clinical advisory pharmacists we require:

- Clinical supervision
- ‘External’ supervision (debriefing etc)
- Mentoring roles
- Peer support

These are roles for CAPA to incorporate in their strategy (Take to the CAPA board in the new year)

For pharmacist prescribers – organize a Peer Group session every second Wednesday evening of the month, 8 pm to 9 pm using ZOOM

Technology and consultations

These are becoming more common – at least telephone ones currently, but secure video in the near future
Ideally require

1. To have met the person face-to-face
2. To have a knowledge of the person
3. Difficult with some aspects perhaps such as inhaler technique?

Brendon will share their guidelines for telephone consultations

Clinical examinations

This is an increasing necessity. To help gain experience it is recommended for every patient to

- Listen to chest
- Listen to heart
- Do blood pressure
- Do heart rate

So this becomes normal … and when you have heard many normal, the abnormal will become apparent